WEST POINT MEDICAL ASSOCIATES

Raymond Baez, MD
Hany S. Guirguis, MD

PATIENT REGISTRATION

CURRENT PATIENT INFORMATION: PLEASE PRINT→

LAST NAME:_____

FIRST NAME:_____

MIDDLE NAME:_____

ADDRESS:_____

CITY:_____ STATE:_____ ZIP CODE:_____

HOME PHONE:_____ MOBILE NUMBER:_____

WORK PHONE:_____

SEX:_____ DATE OF BIRTH:_____/_____/_____

SOCIAL SECURITY NUMBER: XXX - XX -_____ MARITAL STATUS:_____

PATIENT EMAIL: _____

PATIENT PHARMACY:_____PHARMACY LOCATION:_____

EMERGENCY CONTACT INFORMATION:

NAME:_____

RELATIONSHIP:_____ DATE OF BIRTH:_____

PHONE NUMBER:_____

In January 2009, the President signed the “American Recovery & Reinvestment Act” (ARRA). Meaningful Use is an Electronic Health Record incentive program which will improve quality, safety and efficiency of care. To improve care coordination for the patient, ensure adequate privacy and security of personal health information and improve population and public health. The following questions are required to comply with this program. If you would prefer to not answer these questions, please initial the line next to “patient declined”.

Race: _____

Ethnicity: _____

Preferred Language: _____

If you prefer not to disclose this information, please initial: Patient declined: _____

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Medical Records Release Form

PATIENT NAME INFORMATION:

LAST NAME:_____

FIRST NAME:_____

DATE OF BIRTH:_____

ADDRESS:_____

CITY:_____ STATE:_____ ZIP CODE:_____

PHONE NUMBER:_____ CELL NUMBER:_____

EMAIL ADDRESS:_____

INFORMATION REQUESTED FROM: *FAX RECORDS ONLY → DO NOT MAIL*

DOCTOR/FACILITY NAME:_____

ADDRESS:_____ CITY:_____

STATE:_____ ZIP CODE:_____PHONE NUMBER:_____

FAX NUMBER:_____

SEND INFORMATION TO: *FAX RECORDS ONLY → DO NOT MAIL*

PRACTICE NAME: **WEST POINT MEDICAL ASSOCIATES - DR RAYMOND BAEZ & DR HANY GUIRGUIS**

ADDRESS: **1317 WEST POINT DRIVE, COCOA, FL 32922**

PHONE NUMBER: **(321) 324-0434** SECURE FAX: **(855) 576-5128**

ALL RECORDS INCLUDING CLINIC NOTES, LABS, IMAGING, AND PROCEDURES:_____

2 YEAR ABSTRACT RECORDS:_____

I hereby grant permission to release confidential health information about me, by releasing a copy of my medical record to the physician, person, facility, and/or entity.

Patient Name:_____

Patient Signature:_____

Date:_____

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ACKNOWLEDGEMENT OF PRACTICE PRIVACY RIGHTS & CONSENT FORM

CONSENT TO USE OF TEXT MESSAGES/VOICE MAIL:

I consent to the receipt of text and voicemail messages from West Point Medical Associates and/or its agents on any phone number that I provide. If I do not wish to continue receiving text messages, I can discontinue this service at any time.

Initials: _____ Texting: YES / NO Voice mail: YES / NO

Cell Phone Number for Texting: (_____) _____- _____

CONSENT FOR PAYMENT & COLLECTION COMMUNICATIONS:

I agree that West Point Medical Associates and/or its agents, including debt collectors, may contact me through the use of any dialing equipment (including a dialer, automatic telephone dialing system, and/or interactive voice recognition system) and/or artificial or prerecorded voice/messages, even if I am charged for the call or message, for the purpose of servicing my account and collecting amounts due. I agree that such automated calls may be made to any telephone number (including numbers assigned to any paging, cellular, mobile service or any other service) I have provided previously or may provide in the future in connection with my account, unless I have requested confidential communications from West Point Medical Associates and its agents or a restriction on the disclosure of my healthcare information in accordance with the Notice of Privacy Practices and West Point Medical Associates has agreed to such request. With this consent, I waive any claim I may have against West Point Medical Associates and/or its agents, including debt collectors, for the making of such calls, including any claim under federal or state laws and specifically any claim under the Telephone Consumer Protection Act, 47 U.S.C 227, I also agree that this provision applies to the use of text messaging.

I understand there is a risk of a third party accessing my health information when communicated over these media. I understand that I am not required to consent to these types of communications and a decision not to sign this consent authorization will not affect my health care in any way. If I prefer not to consent to these communication methods (opt out of receiving pre recorded telephone and text messages). I understand that West Point Medical Associates will continue to use U.S Mail or regular telephone messaging to communicate with me. I have read this consent and agree that West Point Medical Associates may contact me as described above.

Patient Signature: _____ Date:_____

NOTICE OF PRIVACY RIGHTS & PRACTICES- ACKNOWLEDGEMENT STATEMENT:

I acknowledge that I have received a copy of the West Point Medical Associates Notices of Private Practice. I understand that the Notice of Privacy Practices describes the ways in which West Point Medical Associates may use and disclose my healthcare information for treatment, payment and/or healthcare operations. I understand that I may contact the Privacy Officer identified in the Notice of Privacy Practices if I have questions or a complaint.

Patient Signature: _____ Date:_____

Staff Use Only:
If unable to obtain acknowledgement, describe your attempt to obtain it and why you were unable to do so:

Reason:_____

Staff Signature:_____ Initials:_____ Date_____

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GENERAL CONSENT FOR TREATMENT/TELEMEDICINE/FINANCIAL RESPONSIBILITY

AUTHORIZATION FOR TREATMENT:

I voluntarily consent to the rendering of medical care, treatment and diagnosis; including such diagnostic, therapeutic or medical procedures to be performed by my attending physician, his or her designee, or assistants as is necessary in his/her judgement. I understand that medical diagnosis and treatment may involve substantial risk. I understand that absent emergency or extraordinary circumstances, major therapeutic and diagnostic procedures will not be performed on me unless or until I have had the opportunity to discuss such procedures and the risks associated therewith to my satisfaction with my physician or other health care professional and I have consented to such procedures. I understand that the practice of medicine is not an exact science and I acknowledge that no guarantee has been made to me promising any specific results or outcomes from any diagnostic or therapeutic treatment performed on me at the hospital. Further, I understand and agree that the medical, nursing and other health care personnel in training may participate in my care and treatment as part of their education and training unless I request otherwise. I understand that I have the right to refuse or withhold my consent to any proposed diagnostic or therapeutic procedure. I have been afforded the opportunity to set forth below any limitations to the general consent I have granted herein. **INITIALS: _____**

USE AND RELEASE OF INFORMATION:

I understand that West Point Medical Associates ("WPMA") will keep records that contain my medical, personal and other information related to my diagnosis, care and treatment in electronic, paper and other forms. I understand that WPMA may release any information about me, my health, the health services provided to me or payment for my health services, that may be necessary; 1) for my treatment (to other health care facilities for continuity of care), 2) for any purposes related to payment by me or a third party for services (to determine eligibility, to process insurance claims, for utilization and review, for billing and collection purposes, as necessary to obtain payment) , or 3) for the health care operations of West Point Medical Associates or another health care provider that has had a relationship with me. This information may include genetic test results or other information as needed for these purposes.

INITIALS: _____

TELEMEDICINE:

I understand that WPMA may use telemedicine during the course of my care and treatment. Telemedicine uses audio and video equipment to permit two-way, real time, interactive communication between a patient and a physician or other practitioner who may be located at a distant site. The information gathered during a telemedicine encounter will be maintained in my medical record, privacy and confidentiality of my medical information will be maintained at all times. The hospital will not record the actual or video transmission unless otherwise specified by my physician or practitioner. I understand that I have the right to withdraw my consent for telemedicine at any time without affecting my right to future care or treatment. I also understand that alternative methods of care may be available to me, and I may choose other options at any time. **INITIALS: _____**

ASSIGNMENT OF BENEFITS:

I hereby assign West Point Medical Associates the right to all health insurance benefits otherwise payable to me, and I authorize Medicare and/or medical insurance benefits to be paid directly to West Point Medical Associates. I agree to cooperate and provide information as needed to establish my eligibility for such benefits. A copy of this assignment and authorization may be used in place of the original.

INITIALS: _____

FINANCIAL RESPONSIBILITY

I understand that insurance may not pay the full amount of all of my charges. I acknowledge that I am financially responsible and agree to pay my bill for non-covered services, as well as any deductibles, coinsurances or any amount in excess of insurance benefits. If I am uninsured, I agree to assume full financial responsibility for payment of all charges. **INITIALS: _____**

SIGNATURE:

My signature below constitutes my acknowledgement that I have read and understand the above information, that any questions I have asked have been satisfactorily answered and that I agree to consent of treatment as described Herein.

Patient Signature: _____

Patient Printed Name: _____

Date: ___/_____/_____

Personal Representative printed name: _____

Relationship to patient: _____ Date: ___/_____/_____

Witness and/or Interpreter: _____ Date: _____/_____/_____

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HIPAA GENERAL MEDICAL RELEASE FORM

I hereby authorize the disclosure of my medical information (PHI) by West Point Medical Associates:

Name of person authorizing the release of information:

Patient's Name:_____

Patient's Street Address:_____

City:_____ State:_____ Zip Code:_____

Patient's Date of Birth:_____ Contact Phone Number:_____

I authorize the release of information to: (PLEASE PRINT)

Name:_____ DOB:_____

Relationship:_____ Phone Number:_____

Name:_____ DOB:_____

Relationship:_____ Phone Number:_____

Name:_____ DOB:_____

Relationship:_____ Phone Number:_____

Name:_____ DOB:_____

Relationship:_____ Phone Number:_____

This authorization applies to the following health information (check all that apply):

ALL Records: ☐ Clinic Notes: ☐ Labs: ☐ Imaging Reports: ☐

Vaccines/Immunizations: ☐ Procedures: ☐ Billing: ☐

Patient's Name: (printed)_____

Patient's Signature:_____

Date _____